THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-9252.M5

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address B. Misra, M.D. 2424 50th Street Suite 105 Lubbock, Texas79364	MDR Tracking No.: M5-05-2434-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Zurich Insurance Company Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 2720040556

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
07-14-04	01-03-05	99213	☐ Yes ☒ No
09-13-04	09-13-04	99080	☐ Yes ☒ No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-15-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT code 99080 date of service 09-13-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		07-27-05
Authorized Signature		Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 13, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: ___
MDR Tracking #: M5-05-2434-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopaedic Surgeon reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Letters and office notes from B. Misra, MD

Submitted by Respondent:

- Documents from Flahive, Ogden and Latson
- Professional Associates Peer Review
- Report Cervical x-ray 5-5-04
- Neurosurgery records Matt J. Wills, MD
- Office notes Dr. Misra
- FCE 4-14-04 Kevin McAlpin, DC
- Notes from C. Michael Oliva, MD
- Required Medical Examination Gerald Hill, MD 4-6-04
- Physical Therapy records Dora Roberts Rehab
- Physical Therapy HMC Physical Therapy
- MRI report 9-23-03
- Evaluation by Peter B. Robinson, MD

Clinical History

This is a 52 year old heavy equipment operator who injured his cervical spine when he turned his neck to the right and felt a "pop" while operating a piece of heavy equipment. He complained of burning cervical pain radiating to the right shoulder and along the medial border of his right scapula. His pain has persisted since without improvement. He has been treated with analgesics, anti-inflammatories, physical therapy, epidural steroid injection, and facet blocks without improvement. His cervical x-rays were reported as normal. His EMG and NCV were normal. His MRI shows changes compatible with cervical arthritis and disc dessication and bulging that would not be unusual in a male in his 6th decade of life that does heavy work. His neurologic exam has remained normal. His only findings have been muscle spasm and limited cervical and shoulder motion.

Requested Service(s)

Office visits from 7-14-04 to 1-3-05

Decision

I agree with the insurance carrier that the above visits are not medically necessary.

Rationale/Basis for Decision

Mr. ___ has not responded to extensive conservative measures for his cervical spine. His condition has plateaued. It has not improved nor has it deteriorated. He has no surgical indicators. His findings are compatible with a chronic condition and will, within reasonable medical probability, persist. His MMI date of 6-21-04 is appropriate as there has been no change in his condition since then. The findings in Dr. Misra's notes since MMI have not changed. He notes cervical spasm and limited motion which are not new findings. Regular appointments for this chronic problem are not medically indicated.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 13th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder